**Texas Department of Insurance, Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor's Name and Address:<br><br>Colcris Corp<br>P.O. Box 474<br>Hurst, TX 76053 | MFDR Tracking #:<br>M4-07-4813-01<br><br>DWC Claim<br>Injured Emp |
| Respondent Name and Box #:<br><br>American Home Assurance Co.<br>Rep Box: 19 | Date of Injur<br>Employer N<br>Insurance C |

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DO

Requestor's Position Summary; taken from the table of disputed services: "Insurance carrier did not pay according to DWC fee guidelines for anesthesia."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $189.49
3. CMS 1500
4. Anesthesia Record

Sent
JAN 15 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No Response received.

### PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | CPT Code(s) and Calculations | Part V Reference | Amount Due |
|---|---|---|---|---|
| 09/18/06 | No EOB's | 01991-QS-P2 | 1 - 3 | $00.00 |
| **Total Due:** | | | | $00.00 |

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under procedure code 01991-QS-P2, for DOS 09/18/06.

2. Neither the Respondent nor the Requestor provided EOBs for this date of service. The Requestor did not submit convincing evidence of Respondent receipt for "Request for Reconsideration" in accordance with 133.307 (c) (2) (B). Therefore, the disputed service will be reviewed according to the Medical Fee Guideline.

3. This dispute is not eligible for review per Rule133.304 (m).

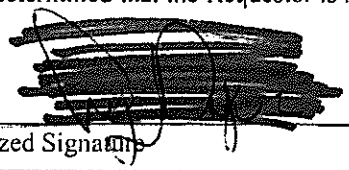
## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G
28 Texas Administrative Code Section 133.307
28 Texas Administrative Code Section 133.304

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

**DECISION :**



[redacted] 01/11/08

Authorized Signature | Medical Fee Dispute Resolution Officer | Date

## PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**